San Antonio Uniformed Services Health Education Consortium (SAUSHEC) Trainee Supervision Policy

I. Applicability

The SAUSHEC Command Council, Board of Directors, and SAUSHEC Graduate Medical Education Committee (GMEC) have approved this policy. It applies to all SAUSHEC staff physicians, dentists, program directors and trainees and establishes minimum requirements for supervision of trainees who provide medical care to patients at Wilford Hall Medical Center (WH) and Brooke Army Medical Center (BAMC). This instruction applies to all personnel assigned, attached or on contract to BAMC and WH. SAUSHEC Graduate Medical Education (GME) program directors will also comply with any additional requirements of their respective residency review committees or accrediting organizations.

II. Definitions and responsibilities.

.A. "Trainee" - a medical, dental, physical therapy, dietetic, intern; resident or fellow who has graduated from a medical, dental, physical therapy, dietetic school respectively, and is either in the first or subsequent training program in a specialty or subspecialty.

B. "Student"– person currently enrolled in a medical, osteopathic, dental, physician assistant, physical therapy school.

C. "Supervising staff provider" --a licensed independent practitioner (LIP) who can supervise trainees and students. This individual has appropriate training, has an unrestricted state license, and has privileges in a field, specialty or subspecialty of medicine which permits him/her to practice without supervision. LIPs may supervise trainees and students in the areas of medical care in which they are privileged, if they are approved to do so by the appropriate program director of the SAUSHEC training program and by the MTF department chair (or equivalent). Supervising staff providers are ultimately responsible for all aspects of patient care within each SAUSHEC training hospital.

D. "Supervision" constitutes any method of staff oversight of patient care for the purpose of ensuring quality of care and enhancing learning; this term does not necessarily require the physical presence or independent gathering of data about the patient on the part of the staff provider.

E. "Team" refers to that group of trainees and staff who share responsibility for the care of a given patient.

F. "Acutely ill" refers to a patient with a condition that is reasonably expected to threaten life, limb, or vital organ function within 24 hours.

G. Medical Treatment Facility (MTF) - a military hospital which is a member of SAUSHEC and in which SAUSHEC residents receive clinical training. BAMC and WH are the two MTF members of SAUSHEC.

H. Institutional clinical authority (ICA) - the institutional official designated in MTF documents who has responsibility for the quality of care provided by LIPs and trainees at that MTF.

I. San Antonio Uniformed Services Health Education Consortium (SAUSHEC) - the GME sponsoring institution for BAMC & WH.

J. Command Council, SAUSHEC, is the institutional governing body (IGB) for military GME in San Antonio. Voting members are the Commanders, BAMC and WH; and the Dean, SAUSHEC. The council approves policies and recommendations developed by the Board of Directors to include making necessary resources available to programs to ensure provision of appropriate resident supervision.

K. Board of Directors, SAUSHEC. Voting members are the Dean, SAUSHEC (Chair); the Deputy Commander, BAMC; Vice Commander, WH; the Associate Deans, SAUSHEC, of BAMC and WH; and the Associate Dean for GME of UTHSCSA. The board is responsible for addressing GME program needs and obligations in planning and decision-making and makes recommendations in these areas to the Command Council.

L. Designated Institutional Official (DIO)—the Dean, SAUSHEC, is recognized by the ACGME to have the authority and responsibility for oversight and administration of GME programs at both SAUSHEC member MTFs.

M. Graduate Medical Education Committee (GMEC) The institutional committee composed of the DIO, program directors, selected faculty and resident representatives whose charter is to monitor and advise on all aspects of GME in the consortium..

N. Program Directors - The institutional officials designated by SAUSHEC who have direct responsibility for all training activities within a residency program, for assuring the quality of educational experiences provided, and appropriate resident supervision.

III. General Principles of Supervision.

A. Careful supervision and observation of trainees by supervising staff is required for teaching, to insure quality patient care and to determine the trainee's ability to perform technical procedures, interpretive procedures and to manage patients. Although not credentialed, trainees must be given graded levels of responsibility while at the same time assuring quality care for patients. This responsibility requires staff availability and appropriate involvement for all patients. Each patient must have a responsible attending whose name is recorded in the patient record and residents must know who the supervisor

of record is for each patient and be able to consult that attending in a timely manner. Supervision of trainees should be graded to provide gradually increased responsibility and maturation into the role of a judgmentally sound, technically skilled, and independently functioning credentialed provider. Each SAUSHEC program director will define policies in his/her curriculum and the mechanism(s) that specify how trainees will become progressively independent in specific patient care activities while still being appropriately supervised by medical staff. Usually this will be accomplished by a job description for each year of training. Supervising staff must be knowledgeable of the graduated levels of responsibility for residents rotating on their service.

B. Program resident supervision policies must be in compliance with the bylaws of the medical staff of each MTF and with JCAHO policies on resident supervision. These policies will delineate the role and responsibilities and patient care activities of trainees and delineate which trainees may write patient care orders, the circumstances under which they may do so, and what entries if any must be countersigned by a supervisor (either a staff or a more senior resident). Ultimately, the supervising staff member is responsible for the care of the patient and for the conduct and performance of all trainees under his/her supervision. The only exceptions occur when a trainee willfully disregards hospital policy or the directions of a staff supervisor, conceals his/her intentions or actions from a staff supervisor, or performs medical care outside the scope of normally delegated responsibility without the knowledge and approval of the supervisor. The program director will insure that all supervision policies are distributed to and followed by trainees and the medical staff supervising their trainees.

C. Compliance with the SAUSHEC resident supervision policy will be monitored by the program directors who will report issues to the GMEC annually in their metric reports, during the internal review process, and prior to the RRC site survey of the program. These reports will be distributed to the governing bodies of BAMC and WH. The program director will determine annually if residents can progress to the next higher level of training. This determination will be documented in the annual assessment of each resident.

D. The GMEC will have representation at appropriate BAMC and WH hospital committees to insure communication occurs on these issues occurs between the GMEC and hospital staff governing bodies.

IV. Trainee Supervision and Documentation Required in Different Patient Care Settings

A. Inpatient Ward/ICU Teams.

1. All lines of authority for inpatient care delivered by inpatient ward/ICU teams will be directed to one credentialed staff provider (usually known as the "attending") who will be clearly identified in the medical record. The attending staff provider has the primary responsibility for the medical diagnosis and treatment of the patient. In the interest of continuity of care and effective trainee supervision, inpatient

staff rotational schedules should allow for a maximum of only two different staff providers to provide daytime coverage for any one inpatient per week. Trainees may write daily orders on inpatients for whom they are participating in the care. These orders will be implemented without the co-signature of a staff physician unless otherwise specified by a program or ward/ICU policy. It is the responsibility of the resident to discuss his/her orders with the attending staff physician. Attending staff may write orders on all patients under their care. Trainees will follow all BAMC or WH policies on how to write orders and to notify nurses, and will follow the verbal orders policies of each patient care area.

2. General job descriptions, supervision and documentation plans by training year for residents on inpatient services are outlined below. The general job descriptions can be modified by program/service specific job descriptions that fit better with their organization.

a. The PGY1 will

(1) Take a complete history and physical (H&P) on all new admissions (unless otherwise specified by a particular teaching service) to the teaching service requiring an H&P, and document them on the approved hospital forms in the patient's chart. After discussion with the attending physician and supervising resident, the PGY1 will write an assessment and initial management plan and institute a therapeutic intervention.

(2) Under the supervision of a more senior resident and/or the attending physician, conduct work rounds, write progress notes which include an interim history and physical exam, laboratory and radiographic data, an assessment and a plan. If a significant new clinical development arises, there will be timely communication by a member of the resident team with the attending. The house staff and attending must communicate with each other as often as is necessary to ensure the best possible patient care.

(3) Be responsible for completion of discharge summaries unless otherwise specified by the program/service.

(4) When required, transfer notes and acceptance notes between critical care units and floor units will be written by the PGY1 unless otherwise specified by the program/service. Such transfer notes shall summarize the hospital course and list current medication, pertinent laboratory data, active clinical problems and physical exam findings. The supervising resident, if any, and the attending must be involved to insure that such transfer is appropriate.

(5) When leaving an inpatient team, PGY1s must write an "off-service" note summarizing the pertinent clinical data about the patient for the oncoming team, unless the program/service has another mechanism to assure communication of patient care data. The new resident team must notify the attending physician of the change in resident teams and must review the management plan with him/her.

b. The PGY2 of an inpatient teaching team will:

(1) Take responsibility for organizing and supervising the teaching service in concurrence with the attending physician, and provide the junior residents and medical students under their supervision a productive educational experience. They work directly with PGY1s in evaluating all new admissions, and in reviewing daily all H&Ps, progress notes and orders written by the junior resident. In consultation with the attending physician, they will also supervise all procedures performed by the PGY1. PGY2s may perform any of the PGY1 tasks outlined above at the discretion of the attending or patient care area policies.

(2) Senior residents must maintain close contact with the attending physician of each patient and notify him/her as quickly as possible of any significant changes in the patient's condition or therapy. All decisions related to invasive procedures, contrast radiology, imaging modalities and significant therapies must be approved by the physician of record.

c. The PGY3 (and above) of an inpatient teaching team will

(1) Follow all responsibilities of the PGY2 outlined above when acting in a similar supervisory capacity. PGY3s may perform any of the PGY1 or PGY2 tasks outlined above at the discretion of the attending or in accordance with patient care area policies.

(2) They will also be available to provide assistance with difficult cases, and to provide instruction in patient management problems when called upon to do so by other residents. When needed, they will assume direct patient care responsibilities to assist more junior residents during times of significant patient volume or severity of illness.

3. Documentation of staff supervision of patient care for hospitalized patients.

Staff supervision of patient care must be documented in the inpatient record. Date, time, signatures, and signature stamps are required on all notes and orders if not performed electronically. Documentation requirements for inpatient care are outlined below.

a. Documentation that must be performed by staff:

(1) Documentation in writing of concurrence with the admission, history, physical examination, assessment, treatment plan and orders is required within 24 hours of admission.

(2) Within 24 hours of admission staff must co-sign the short form history and physical or its equivalent on the abbreviated medical record.

(3) Documented concurrence with major therapeutic decisions--such as "Do Not Resuscitate" status--is required by specific mention in a staff written progress note.

(4) Staff notes are required at least weekly for non-special care unit patients; and in the ICU for any significant change in patient status or change in plan.

(5) All notes by medical or dental students must be co-signed by a staff provider if not previously signed by a trainee. Further, the staff provider who signs a student note is responsible for all its content.

b. Documentation that can be done by trainees:

(1) Trainees must document patient care and staff supervision by writing progress notes and/or co-signing notes written by medical or dental students. The condition of the patient determines how often progress notes are written. Trainee progress notes are written at least daily on all patients who are acutely ill or for the first five days after major surgery.

(2) Required documentation of staff supervision can be accomplished by the trainee, e.g., "Dr. Smith (the attending) concurs with…" in the following situations:

(a) For admissions to critical care units, there must be documentation of notification of the admission and concurrence of the staff or fellow with trainee health care plans within four hours of admission.

(b) Documenting staff concurrence with discharge plans before the patient is discharged.

(c)Documenting staff concurrence with decision to transfer patient to another provider, service or facility.

(d) Documenting staff concurrence with issues dealing with advance directives, informed consent and refusal of care.

B. Inpatient Consult Teams.

All inpatient consultations performed by trainees will be documented in writing with the name of the responsible staff consultant recorded. The responsible staff consultant must be notified verbally by the trainee doing the consult within an appropriate period of time as defined by the particular consulting service. The consulting staff is responsible for all the recommendations made by the consultant team. If requested by the patient's primary staff, the consulting staff must see the patient.

C. Operating room.

The staff physician must be present in the operating room area for the critical parts of all major cases. A major case is defined as a procedure that enters a major body cavity or has potential for mortality, significant morbidity or significant blood loss. Any procedure performed on a patient with major risks from anesthesia due to underlying medical problems will be considered a major case. In some cases, even positioning of the patient may be considered critical. Even in his or her absence from the operating room area, the staff physician remains responsible for proper patient and operative site identification as well as for the care of the patient. If, in the opinion of the staff, a surgical procedure is minor and of low potential for significant morbidity, the procedure may be performed under the direction of a qualified surgical resident as defined in the training program's curriculum after proper identification of patient and operative site.

D. Outpatient clinics.

All outpatient visits provided by trainees will be done under the supervision of a staff provider. This staff provider will interview and examine the patient at the staff's discretion, at the trainee's request, or at the patient's request. For all patients new to a clinic with a significant problem, the staff will examine or discuss the patient with the resident prior to the patient leaving the clinic. The staff doctor has full responsibility for care provided, whether or not he/she chooses to personally verify the interview or examination. The name of the responsible supervising staff will be clearly recorded in the patient record.

E. Emergency Room.

The responsibility for supervision of trainees providing care in the Emergency Room to patients that are not admitted to the hospital will be identical to that outlined in the scheme for outpatient clinic supervision above. The responsibility for supervision of trainees who are called in consultation on patients in the Emergency Room will be identical to that outlined in the scheme for consultation supervision above. Consulting staff should be notified promptly of Emergency Room consultations.

F. Interpretive settings.

Trainees who primarily interpret laboratory, radiology or pathology specimens must also be supervised and this supervision must be documented. It is the responsibility of each training program/department in these areas to establish supervisory regulations in compliance with JCAHO and ACGME requirements.

V. Supervision of procedures.

A. A trainee will be considered qualified to perform a procedure if, in the judgment of the supervising staff and his/her specific training program guidelines, the trainee is competent to safely and effectively perform the procedure. Residents at specified year levels in a given training program may be designated as competent to

independently perform certain procedures based upon specific written criteria set forth and defined by the program director. In this instance, trainees may perform routine procedures that they are deemed competent to perform (such as arterial line placement) for standard indications without prior approval or direct supervision by staff. However, the patient's staff of record will ultimately be responsible for all procedures on inpatients. In addition, residents may perform emergency procedures without prior staff approval when life or limb would be threatened by delay. In this case the most senior trainee available will supervise the procedures.

B. All outpatient procedures will have the staff of record documented in the procedure note and that staff will ultimately be responsible for the outpatient procedure. Students will not perform procedures without direct supervision of an LIP or a trainee qualified to perform the procedure independently.

VI. Emergency Situations.

An "emergency" is defined as a situation where immediate care is necessary to preserve the life of, or to prevent serious impairment to the health of a patient. In such situations, any resident is permitted to do everything possible to save the life of a patient or to save a patient from serious harm. Residents will make all reasonable efforts to obtain assistance from more senor residents and/or any staff available in the hospital and will contact the appropriate attending as soon as possible. The resident will document all aspects of the emergency patient care, including who was contacted, in the patient's record.

VII. Trainee grievances regarding supervision.

It is the program director's responsibility to insure trainees are aware that any concerns they have regarding adequate technical or professional supervision, or professional behavior by supervisors will be addressed in a safe and non-threatening environment per SAUSHEC and ACGME guidelines. All SAUSHEC GME programs must follow the SAUSHEC Resident Grievance Policy. Trainee grievance procedures through program director, department chief, ombudsman, and Inspector General must be maintained in all training programs in order to ensure that fair and just relationships between students and faculty can be perpetuated. Grievance procedures will be established for each department/training program, and will be clearly stated and made available to all trainees during their orientation to that department/program.